

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3957 **63-050290** STATE FILE NUMBER

FILED JAN 9 1964

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside, corporate limits, give TOWNSHIP only) <u>Florissant Township</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in 1b <u>2-5mo</u>		Inside Limits <u>Yes</u> <input type="checkbox"/> <u>No</u> <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>Vista Bella Home</u>		d. STREET ADDRESS (If outside, give location) <u>4360 Wallace</u>	
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm <u>Yes</u> <input type="checkbox"/> <u>No</u> <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>LEOTIA</u> Middle <u>McComb</u> Last <u>McComb</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>17</u> Year <u>1963</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 6, 1915</u>	9. AGE (last birthday) <u>89</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>
11. BIRTHPLACE (City and state or country) <u>Unknown</u>			12. CHIEF OF WHAT COUNTRY <u>AMERICAN</u>		
13a. FATHER'S NAME <u>Collard</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		
14. NAME OF HUSBAND OR WIFE <u>Wilford R. McComb</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>		
16. SOCIAL SECURITY NO. <u>—</u>			17. INFORMANT <u>Blanche Monks, 12499 Columbia Bottom Rd.</u>		

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>491x</u>	
	DUE TO (c) <u>—</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebral Thrombosis</u>		PART III. If deceased was female there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> <u>NONE</u>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>—</u>	
20c. TIME OF INJURY Hour <u>—</u> a.m. <u>—</u> p.m. <u>—</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. CITY, TOWN, OR LOCATION <u>St. Louis, Missouri</u>
21. I attended the deceased from <u>April 1962</u> to <u>12-17-63</u> and last saw her alive on <u>11-23-63</u> Death occurred at <u>12-17-63</u> <u>12:00</u> A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			

22. SIGNATURE (Degree or title) <u>Allen M. Murney M.D.</u>	22b. ADDRESS <u>860 N Woodlawn</u>	22c. DATE SIGNED <u>12-17-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Anatomical</u>	23b. DATE <u>12-26-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical</u>
23d. LOCATION (City, town, or county) <u>St. Louis, Missouri</u>		(State)

24. FUNERAL DIRECTOR <u>Anatomical Board, St. Louis, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12-26-63</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO.

DATE AMENDED

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Not embalmed. Received by Missouri State Anatomical Board,
December 1963

Calvin A. Richins

Calvin A. Richins, Ph.D.,
Local Sec. for St. Louis

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.